

| | |
|-----------------|---------------|
| Appointment w/: | Today's Date: |
|-----------------|---------------|

Patient Information:

| | | | | |
|----------------------|--------------|------------|----------------------|----------|
| Last Name | | First Name | | M |
| Date of Birth | Age | Sex | Marital Status | |
| Street Address | | City/State | | Zip Code |
| Home Phone # () | Mobile # () | Work# () | Email | |
| Mother's First Name: | | | Father's First Name: | |

This is for medical record purposes only.

Employer Information:

| | |
|------------|-------------------------|
| Occupation | Employer's Name/Address |
|------------|-------------------------|

Emergency Contact Information:

| | | |
|------|--------------|-------------|
| Name | Relationship | Phone # () |
|------|--------------|-------------|

Referral Source (From whom/how did you hear about this Provider?):

Name/Type: Physician Family or Friend Website/ Search Advertisement Other _____

| | | |
|-------------------------|---------|-------------|
| Primary Care Physician | Address | Phone# () |
| Cardiologist | Address | Phone# () |
| Physician (Other) _____ | Address | Phone # () |

Insurance Information:

| | | | | |
|---|-------------|---------------|------------------------|----------------|
| Patient Relationship to Guarantor (circle one) | SELF | SPOUSE | DEPENDENT CHILD | STUDENT |
| Primary Insurance | | | Policy # | |
| Guarantor Name | | | DOB | |
| Secondary Insurance | | | Policy # | |
| Guarantor Name | | | DOB | |

Pharmacy Information:

| | | | |
|--------------------|------------------------|----------------------------|-------------|
| Circle One: | Retail Pharmacy | Mail-Order Pharmacy | Name |
| Address | | | Phone # () |

Authorization for Treatment and Release of Information

I hereby authorize and direct the above named clinical practice having treated me, to release to governmental agencies, insurance carriers, or others financially liable for my medical care, all information needed to substantiate payment for such medical care; and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. I furthermore authorize the treating physician/practice to take and use my photos for insurance predetermination and educational purposes.

Financial Responsibility (For Provider Indicated in the "Appointment w/" section of this form)

Medicare Patients: I request that payment of authorized health insurance benefits be made to me or on my behalf to the provider(s) for any services furnished to me by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration, and its agents, any information needed to determine these benefits or the benefits payable for related services.

Commercial/Other Insurance: I hereby authorize direct payment of surgical/medical benefits to my provider, for services rendered by him/her in person or under his/her supervision if I have not paid in advance. I understand that I am financially responsible for all services. Additionally, I understand that all bills are my responsibility if not paid by the carrier.

Out of Network: I understand that the doctor is a **non-participating provider** of my insurance and therefore I will be responsible for any balances on this account.

Self-Pay: I agree to pay at the time the services are rendered.

| | | |
|--|-----------------------------------|------|
| I verify the accuracy of the above information and authorize treatment and release of information as indicated on this form. | Patient (Guardian) Signature X | Date |
| I understand and agree to terms of my financial responsibility as indicated on this form. | Patient (Guardian) Signature X | Date |



COLUMBIA UNIVERSITY
MEDICAL CENTER

Jeffrey Ascherman, MD

161 Fort Washington Avenue, N Y, 10032
Office 212-305-9612 Fax 212-305-9626

Patient Name:

MRN

Please answer the questions below:

Please list ALL of your current medications:

List any allergies and reactions (including rash, hives, throat swelling, anaphylaxis)

List any surgeries you have had and the approximate date:

Patent Name: _____

HAVE YOU EVER HAD (been diagnosed or treated for) **ANY OF THE FOLLOWING** (if yes, describe):

| | | |
|-----------------------------|------------|-------|
| Heart Disorder | Yes__ No__ | _____ |
| Cancer | Yes__ No__ | _____ |
| Diabetes | Yes__ No__ | _____ |
| Blood Pressure Disorder | Yes__ No__ | _____ |
| Thyroid Disorder | Yes__ No__ | _____ |
| Lung Disorder | Yes__ No__ | _____ |
| Stomach/Intestinal Disorder | Yes__ No__ | _____ |
| Skin Disorder | Yes__ No__ | _____ |
| Clotting Disorder | Yes__ No__ | _____ |
| Psychologic Disorder | Yes__ No__ | _____ |
| Urinary/Kidney Disorder | Yes__ No__ | _____ |
| Liver Disorder | Yes__ No__ | _____ |
| Orthopedic Disorder | Yes__ No__ | _____ |
| Cholesterol Disorder | Yes__ No__ | _____ |
| Neurologic Disorder | Yes__ No__ | _____ |
| Other | Yes__ No__ | _____ |

SOCIAL HISTORY:

Occupation: _____

Children? Yes__ No__ ages _____

Smoking:

Currently? Yes__ No__

Previously? Yes__ No__ Years Smoked _____ packs per day _____

PHYSICAL EXAM:

Height _____ ft _____ in

Weight _____ lbs.



**COLUMBIA UNIVERSITY
MEDICAL CENTER**

Health Insurance Portability and Accountability Act (HIPAA)
HIPAA Compliance/Columbia University Medical Center
601 West 168th Street, Apt. #22, 2nd Floor
New York, NY 10032 / T(212) 342-0059 F(212)342-5173
<http://www.cumc.columbia.edu/hipaa/>

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

DATE: _____

I acknowledge that I was provided with a copy of the Columbia University Medical Center Notice of Privacy Practices.

Patient Name (Print)

Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below

Personal Representative (Print)

Personal Representative's Signature

Relationship

For Columbia University Medical Center use only.

Complete this section if this form is not signed and dated by the patient or patient's representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Columbia University Medical Center's Notice of Privacy Practices but was unable to for the following reason:

- Patient refused to sign
- Patient unable to sign
- Other _____

Employee Name

Date

This form should be placed in the patient's medical record